2514) 001 - $350.00
2514) 006 - $ 10.00
$360.00

TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS
227 FRENCH LANDING DRIVE, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243
LOCAL (615) 532-3202, ext 25135
TOLL FREE 1-800-778-4123, ext. 25135
www.tennessee.gov

APPLICATION FOR LICENSE AS A NURSING HOME ADMINISTRATOR

INSTRUCTIONS

1. Complete this application, have it notarized, enclose a non-refundable check for $360.00 payable to the Board of Examiners for Nursing Home Administrators, and mail it to the above address. Please type or print legibly.
2. Attach one (1) signed "passport" style photograph to the front of this application.
3. Attach, or have sent, two (2) original letters of reference written on signator's letterhead stationery (no copies). These letters must verify your good moral character.
4. Attach one (1) notarized photocopy of a birth certificate, naturalization papers or current visa.
5. Request your transcript from the College or University you obtained the degree and have it sent directly to the Board Office at the above address. Your transcript should state the name of the High School and the date you graduated.
6. A criminal background check must be submitted. For instructions on how to obtain a criminal background, **click here**.

NAME _____
First Middle and/or Maiden Last

DATE OF BIRTH _____ SOCIAL SECURITY # _____

CURRENT HOME MAILING ADDRESS: CURRENT PRACTICE ADDRESS:

_____ _____
_____ _____
_____ _____

HOME PHONE # _____ WORK PHONE # _____

HOME E-MAIL ADDRESS _____ WORK E-MAIL ADDRESS _____

List all states where you currently have, or have ever had, a Nursing Home Administrator license. If you need additional space please attach information to the back of this page.

_____ _____ _____ _____ _____

If you have an associate, baccalaureate, masters, or doctorate degree please list the following:

Name of College or University: _____ Type of Degree Awarded: _____

Major: _____ Date of Graduation: _____

EDUCATION AND/OR EXPERIENCE REQUIREMENT

Please indicate which educational and/or experience requirement you have completed for licensure in Tennessee or the requirement you completed to receive a nursing home administrator's license in another state.

( ) 1. Baccalaureate, masters or doctorate degree in the area of health care administration with an Internship in a long term care facility from an accredited college or university.

( ) 2. Baccalaureate, masters or doctorate degree from an accredited college combined with a Board approved Administrator-In-Training program.

( ) 3. Associate degree and three (3) years of acceptable management experience as defined in rule 1020-1-.01 (1), combined with a Board approved Administrator-In-Training program.

( ) 4. Five (5) years of acceptable management experience as defined, in rule 1020-1-.01(1), combined with a Board approved Administrator-In-Training program and fifty (50) clock hours of board approved continuing education in nursing home administration. The fifty (50) clock hours of Board approved continuing education in nursing home administration referred to in this rule must have begun and be successfully completed within twenty-four (24) months immediately prior to approval for or beginning of the Administrator-In-Training program.

( ) 5. Hospital administrator and/or assistant or associate/hospital administrator with five (5) or more years in full time hospital administration in the last seven (7) years.

If you marked Box 1, complete pages 1, 2, 3, and 4 and have your college or university send a sealed transcript directly to the Board office. Enclose a resume for at least five (5) years listing last employment first, including proof internship was completed in a long term care facility. Please indicate on your resume the facility where you completed your internship.

If you marked Box 2, complete pages 1, 2, 3, 4, and 6, and have your college or university send a sealed transcript directly to the Board office. Also, have your preceptor complete page 7 and have him/her retain pages 8 and 9. Enclose a Resume for at least five (5) years listing last employment first.

If you marked Box 3, complete pages 1, 2, 3, 4, and 6, and have your college or university send a sealed transcript directly to the Board office. Also, have your preceptor complete page 7 and have him/her retain pages 8 and 9. Enclose a resume for at least the last five (5) years, listing last employment first.

If you marked Box 4, complete pages 1, 2, 3, 4, and 6, and have your preceptor complete page 7. Also, have him/her retain pages 8 and 9. Enclose a resume for at least the last five (5) years listing last employment first, and enclose proof of successful completion of the fifty (50) clock hour continuing education requirement.

If you marked Box 5, complete pages 1, 2, 3, 4 and 5, and enclosed a resume for at least the last five (5) years, listing last employment first.

If you are applying by Reciprocity choose 1 thru 5 of how you are educationally qualifying and complete pages 1, 2, 3, 4 and 5.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application. For the purpose of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice as a Nursing Home Administrator"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate decisions (if necessary) and exercise reasoned judgment and to learn and keep abreast of development in the field.

   b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers.

   c. The physical capability to perform tasks and procedures required or your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

3. **"Chemical Substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

5. **"Illegal Use of Controlled Substances"** means the use of controlled substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a Nursing Home Administrator with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner, in which you have chosen to practice?	_____	_____
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether conditions should be imposed or whether you are not eligible for licensure.)	_____	_____
2. Do you currently use chemical substances?	_____	_____
If yes, do they in any way limit your ability to practice as a Nursing Home Administrator with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice as a Nursing Home Administrator or any other health care professional in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked or otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a Professional Association?	_____	_____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you?	_____	_____
b. Have you ever had settlement of any legal action rendered against you?	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____

AFFIDAVIT OF APPLICANT

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in or in connection with my application may be cause for denial or loss of my license.

I further swear that I have read and understand the statues and the Rules and Regulations which were enclosed in the application packet and agree to abide by them while licensed by Tennessee.

I also authorize the Board of Examiners for Nursing Home Administrators to be informed if my name appears on the Tennessee Abuse Registry and do hereby waive the confidentiality of said information only for the limited purpose of processing my licensure application.

In order to comply with federal statutes, the Tennessee Board of Examiners for Nursing Home Administrators is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

_____
Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, _____.

Commission Expires: _____ _____
(Date) (Notary Public)

Notary Seal

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING DRIVE, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243

TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as a Nursing Home Administrator. (If additional forms are required, this form may be duplicated.) Please disregard this page if you are not licensed or have never been licensed as a nursing home administrator in another state.

NOTE: Some states require a fee for providing verification information. In order to expedite your application, you may wish to contact the applicable state or states.

****

I was granted _____ on _____ by the State of _____
(License #) (Date)

The Tennessee Board of Examiners For Nursing Home Administrators requests that I submit evidence that my License in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Examiners For Nursing Home Administrators.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

****

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _____ Date Issued: _____

Basis of Issuance: Endorsement/Reciprocity With: _____
(Provide Description of Exam)

Written Examination: NAB _____ PES _____ OTHER _____ DATE _____

Raw Score _____ Scale Score _____

Was an A.I.T./Practicum successfully completed: _____ Length of A.I.T./Practicum _____

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No
If "yes" please attach explanation.

_____
Authorized Signature

_____ State Seal
Title

_____
Date

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING DRIVE, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243

TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS

Local (Nashville Calling Area) (615) 532-3202, ext. 25135
Nationwide (toll free) 1-800-778-4123, ext. 25135

Application for Administrator-in-Training

Name: _____

Facility name _____
& Address: _____
Street City State Zip

_____ ( ) _____
County Telephone

I have entered into an agreement with _____ License # _____
to serve as my preceptor during the period approved by the Board.

I hereby agree to hold the Tennessee Board of Examiners for Nursing Home Administrators, its members, officers, staff and examiners free from any damage or complaint by reason of any action they, or any of them, may take in connection with this application.

I understand that my A.I.T. program may not begin until notification of approval of my application by the Board.

I further understand that approval of my A.I.T. application does not imply approval to take the Nursing Home Administrators License Examination. Approval of qualifications to take the examination will be made after I complete my A.I.T. program.

I am also aware that I shall be assigned responsibilities in departmental rotation eight consecutive hours daily (except for regular days off), with a minimum of forty hours per week unless alternate arrangements are made with the Board in writing.

I further agree that I shall have no other "full or part time" work assignments in the facility during training hours, or any outside employment, unless such employment is known to and approved in writing by the Board and the preceptor prior to the start of my A.I.T. program.

By voluntarily entering into the A.I.T. program in an effort to become licensed as a Nursing Home Administrator, you are giving your permission to your Preceptor to evaluate your performance as regarding your qualifications as an administrator. You should consult your attorney concerning any legal relationship or right as between you and your Preceptor.

I will submit the most recent survey of the facility in which I will complete my A.I.T. program.

APPLICANT'S SIGNATURE IN FULL _____

Subscribed and sworn before me this _____ day of _____, _____.

My Commission Expires: _____

_____
Notary Public

(SEAL)

Tennessee State Board of Examiners for Nursing Home Administrators
227 FRENCH LANDING DRIVE, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243
Local (Nashville Calling Area) (615) 532-3202, ext. 25135-Nationwide (toll free) 1-800-778-4123, ext. 25135

PRECEPTOR AND ADMINISTRATOR-IN-TRAINING APPLICATION FOR TRAINING FACILITY

The primary training of an Administrator-In-Training will take place in the Nursing Home of which the Preceptor is Administrator.

Name of Nursing Home: _____

Address: _____

_____
Street and Number

_____
City, State, Zip

Telephone (_____) _____

Attach a copy of the latest licensure survey and the plan of correction for any deficiencies.

The facility must have an organizational structure with clearly defined and staffed departments, each with a designated department head. Except for administration, the designated department head may not be the administrator.

DEPARTMENT	NAME OF DEPARTMENT HEAD
Administration:	_____
Nursing:	_____
Dietary:	_____
Social Services and Activities:	_____
Medical Records:	_____
Housekeeping, Maintenance, Laundry:	_____
Number of Beds:	_____

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

I, _____, the Administrator of Home, hereby make application to the Tennessee State Board of Examiners for Nursing Home Administrators for approval of this Nursing Home as an Administrator-In-Training facility and for approval to function as a preceptor. All facts, statements and answers contained in this application are true and correct, to the best of my knowledge. I have not omitted any information which might be of value to the Board in determining the qualifications of this Nursing Home, whether it is called for or not, and I understand that any falsification, omission or withholding of information or facts concerning the home's qualifications shall be sufficient to bar it from this or any future certification given by the Tennessee State Board of Examiners for Nursing Home Administrators as an A.I.T. site.

_____
Signature of Administrator

_____
Date

County of _____ State of _____

Sworn to and subscribed before me by the above this _____ day of _____, _____.

_____
Notary Public

My Commission Expires: _____

TENNESSEE BOARD OF EXAMINERS
FOR NURSING HOME ADMINISTRATORS
227 FRENCH LANDING DRIVE, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243

Local (Nashville Calling Area) (615) 532-3202, ext. 31935
Nationwide (toll free) 1-800-778-4123, ext. 31935

ADMINISTRATOR-IN-TRAINING
PROGRESS REPORT NUMBER: _____

Name of A.I.T.: _____

Name of Preceptor: _____

Training Site: _____

Date A.I.T. program began: _____

Dates covered by this report: _____

1. List assignments and departments with time spent in each: _____

_____

2. Summary of learning experiences: _____

_____

3. Brief analysis of any problems observed, new experiences, insights gained: _____

_____

4. Statement of any problems that arose during the period: _____

_____

5. Visits outside the facility, educational conferences attended: _____

_____

I certify, to the best of my knowledge, that the information presented is true and accurate and I have had at least four (4) hours of face-to-face training with this A.I.T. each week of this reporting period.

_____ _____
Signature of Preceptor Date

Progress reports must be submitted every 2 months. **Make extra copies of this page.** Additional comments may be made on a separate sheet of paper. **(Do not change any party of this form.)**

TENNESSEE BOARD OF EXAMINERS
FOR NURSING HOME ADMINISTRATORS
227 FRENCH LANDING DRIVE, SUITE 300
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Local (Nashville Calling Area) (615) 532-3202, ext. 25135
Nationwide (toll free) 1-800-778-4123, ext. 25135

Evaluation Report of the Six (6) Month A.I.T. Program
Must be in BENHA Office for Approval by the FULL Board
This Evaluation Report must be submitted with the third (3rd) and Final Report

I, _____ Preceptor for _____ certify that he/she has successfully completed the Administrator-in-Training program at _____ Nursing Home.

I certify that I have had at least four (4) hours face-to-face training with this A.I.T. each week of the training.

The Administrator-in-Training program began on _____ and was completed on _____.

During this period there was a total of _____ hours spent in the training program. The hours were divided as follows:

Department	Hours
Administration	
Activities	
Bookkeeping	
Business Office	
Dietary	
Housekeeping	
Laundry	
Maintenance	
Medical Records	
Nursing	
Social Services	
Other:	
Total Hours	

On a separate sheet of paper, please evaluate this prospective administrator. The Board needs your evaluation of the A.I.T.'s strengths and weaknesses in each of the above areas in order to properly guide him/her toward licensure. **All reports, evaluation report, evaluation of A.I.T.'s strengths and weaknesses and recommendation letter to sit the NAB examination must be in the BENHA Office before the applicant can be approved to sit for the examination.**

_____ _____
Signature of Preceptor Date

KSR/G4060154/NHA

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider to</u>:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records</u>.**

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER:_____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(____)_____ **(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.
1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:
1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)
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